



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name

CITY OF HOUSTON

Carrier's Austin Representative Box

Box Number 29

MFDR Tracking Number

M4-07-2865-01

MFDR Date Received

January 4, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: \$6,234.04

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...the Respondent has developed and consistently applies a methodology to determine a fair and reasonable reimbursement amount to ensure that similar procedures provided in similar circumstances receive similar reimbursement. The Respondent has issued a fair and reasonable payment for this outpatient, non-trauma, non-rural surgery... Regardless of the methodology employed by the Respondent to ensure a fair and reasonable reimbursement, the burden remains solely upon the Requestor to show that the amount it seeks is fair and reasonable. The Requestor has failed to meet its burden."

Response Submitted by: Harris & Harris, 5900 Southwest Parkway, Building 2, Suite 100, Austin, Texas 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2006	Outpatient Hospital Services	\$6,234.04	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the

absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on January 4, 2007. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 22, 2007 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 142 – Charge included in facility fee
 - W10 – Payment based on fair & reasonable methodology
 - 97 – Charge Included in another Charge or Service
 - 45 – Contract/Legislated Fee Arrangement Exceeded
 - 510 – Payment Determined

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."
 - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
 - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that "The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus

managed care contract.... It also shows numerous Insurance Carriers' willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services."

- The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
 - Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit "A", dated 04/23/92, which states that "OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES."
 - The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that "services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database."
 - The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive "an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database."
 - No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
 - No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
 - The requestor's position statement further asserts that "amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers' compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code §413.011 as they are 'relevant to what fair and reasonable reimbursement is,' 'they are relevant to achieving cost control,' 'they are relevant to ensuring access to quality care,' and they are 'highly reliable.' See 22 Tex. Reg. 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services."
 - While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that the requested alternative reimbursement methodology would satisfy the requirements of 28 Texas Administrative Code §134.1.
- The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by

the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>June 15, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.